

Moda Health 2025-26 Plan Year

**Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments**

(Effective October 1, 2025)



Medical & Pharmacy			
OEBB Plan	Tier-Rated Groups		
Moda Medical Plans	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Moda Medical Plan 1	\$1,153.47	\$865.16	\$2,018.66
Moda Medical Plan 2	\$1,070.04	\$802.57	\$1,872.63
Moda Medical Plan 3	\$1,003.89	\$752.96	\$1,756.87
Moda Medical Plan 4	\$947.88	\$710.93	\$1,658.88
Moda Medical Plan 5	\$875.64	\$656.77	\$1,532.40
Moda Medical Plan 6*	\$893.17	\$669.90	\$1,563.09
Moda Medical Plan 7*	\$833.58	\$625.24	\$1,458.85

* This plan MAY be paired with an HSA (Health Savings Account), but the HSA is not required. Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible. Once the deductible is met Rx's are paid at the same level as other covered medical expenses.

Vision			
OEBB Plan	Tier-Rated Groups		
May use any licensed provider	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Opal Plan	\$26.16	\$19.57	\$45.77
Pearl Plan	\$21.43	\$16.06	\$37.45
Quartz Plan	\$15.13	\$11.33	\$26.41



Member Services
1-888-469-6322
OEBB.Benefits@odhsoha.oregon.gov

Moda Health/ODS 2025-26 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
(Effective October 1, 2025)



Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Provider network noted in plan name below	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Premier Plan 1 - Delta Dental Premier Network	\$68.15	\$83.55	\$157.14
Premier Plan 5 - Delta Dental Premier Network	\$60.17	\$73.78	\$138.78
Premier Plan 6* - Delta Dental Premier Network	\$45.88	\$47.28	\$96.95
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	\$59.06	\$72.42	\$136.20
Exclusive PPO Plan** - Delta Dental PPO Network	\$39.79	\$48.80	\$91.80

* This plan has no orthodontia coverage

** This plan has no out-of-network benefit. Services performed by providers outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and x-rays. All other services are considered non-covered.

Kaiser Permanente 2025-26 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
(Effective October 1, 2025)



Medical and Pharmacy			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner Child(ren) Only	Domestic Partner + Domestic Partner Child(ren)
Kaiser Medical Plan 1	\$1,026.22	\$769.67	\$1,795.88
Kaiser Medical Plan 2A	\$896.99	\$671.88	\$1,569.02
Kaiser Medical Plan 2B	\$875.69	\$655.93	\$1,531.78
Kaiser Medical Plan 3*	\$678.99	\$508.24	\$1,187.26

* This plan MAY be paired with an HSA (Health Savings Account), but the HSA is not required. Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible. Once the deductible is met Rx's are paid at the same level as other covered medical expenses.

Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner Child(ren) Only	Domestic Partner + Domestic Partner Child(ren)
Kaiser Dental Plan	\$90.94	\$68.21	\$159.12

Vision			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner Child(ren) Only	Domestic Partner + Domestic Partner Child(ren)
Kaiser Vision Plan	\$10.18	\$7.63	\$17.82



Member Services
1-888-469-6322
OEBB.Benefits@odhsoha.oregon.gov

Williamette Dental Group 2025-26 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
(Effective October 1, 2025)



Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Must use Willamette Dental Group facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner Child(ren) Only	Domestic Partner + Domestic Partner Child(ren)
Willamette Dental Plan	\$48.17	\$54.45	\$105.76

VSP Vision 2025-26 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
(Effective October 1, 2025)



OEBB Plan	Vision		
	Domestic Partner	Domestic Partner Child(ren) Only	Domestic Partner + Domestic Partner Child(ren)
Vision plans using the VSP Choice network			
VSP Choice Plus Plan	\$16.99	\$12.75	\$29.72
VSP Choice Plan	\$8.25	\$6.19	\$14.44